Florida GulfCoast
Physical Therapy LLC

PATIENT INFORMATION SHEET

Patient Name_____ **Phone #**_____
Address (Florida):_____
City_____ **State**_____ **Zip Code**_____
Address (Not Florida):_____
City_____ **State**_____ **Zip Code**_____ **Phone #**_____
Social Security #_____ **Birth date**_____
Sex (circle one) Male Female
Marital Status (circle one) Single Married Divorced Separated Widowed
Insurance Company (Primary)_____ **ID#**_____ **Phone #**_____
Insurance Company (Secondary)_____ **ID#**_____ **Phone #**_____

Please fill out the following information if your insurance is not in your name:

Insured's Name_____ **Relation**_____ **DOB**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Are you able to work?(circle) yes no **Occupation**_____ (circle) Full time Part time
Employer_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Date of injury, surgery or onset of symptoms (mm/dd/yy) please be specific_____
Possible cause for injury (fall, car accident, work related):_____
If due to car accident or work, did you report the accident? (circle one) Yes No

Please fill out the following information if you were in a motor vehicle accident:

Insurance Company_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____
Case Manager_____ **Claim #**_____
Attorney_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Please fill out the following information if you sustained your injury at work:

Insurance Company_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____
Case Manager_____ **Claim #**_____

Are you currently receiving any other treatments:_____
Are you currently receiving home health services: Yes No **If yes answer below**
Home health company name_____
Phone #_____ **Contact** _____
When was your last visit?_____ **Are they scheduled to return?** Yes No

Thank you for your cooperation. If you are unable to keep your scheduled appointments, please notify us within 24 hours before your scheduled appointment time. A $25 fee will be assessed for missed appointments without a 24 hours notice.

I have read and understand the policy regarding fees and agree to pay any remaining balance. I authorize payment directly to Florida GulfCoast Physical Therapy. I authorize consent to copy and release PT records of treatment, charges, and reports to physicians and other parties, as indicated.

What are your goals for therapy? _____

Patient Signature:_____ **Date**_____

Florida GulfCoast
Physical Therapy LLC

Phone: 239-948-2222
Fax: 239-948-2225
Web: flgulfcoastpt.com

Name_____
Diagnosis / complaint_____
Date of injury / onset of symptoms_____
Symptoms_____
Tests:(circle all that apply) **x-ray** **MRI** **CT scan** **arthrogram** **sonogram** **EMG** **NCV** **Bone density**
Results:_____
Pain description: (circle all that apply) **Sharp** **Dull** **Achy** **Shooting** **Stabbing** **Stiff** **Throbbing**
Other:_____
Do you experience: (circle all that apply) **Numbness** **Tingling** **Burning** **Weakness** **Cramping**
Other:_____

Please mark the lines below as indicated

Pain at best (0/10 = no pain, 10/10 pain = emergency)

0_____5_____10

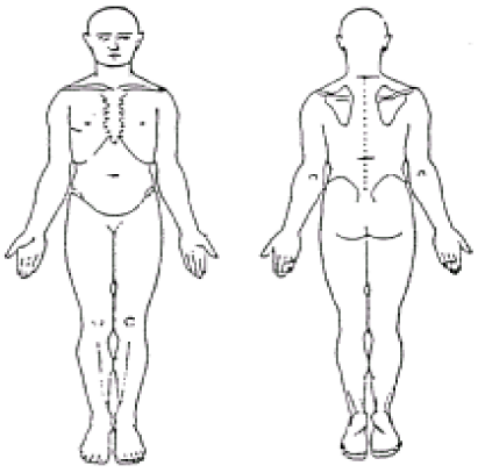
Pain at worst (0/10 = no pain, 10/10 pain = emergency)

0_____**5**_____**10**

Current pain (0/10 = no pain, 10/10 pain = emergency)

0_____**5**_____**10**

Right Left Left Right



Put an 'X' on the diagram above where you feel pain.

Is your pain: (circle) Constant Intermittent At regular intervals
Does your pain: (circle) prevent sleep wake you from sleep feel better after sleep feel worse after sleep not influenced by sleep
What increases your symptoms?_____
What decreases your symptoms?_____
Do you have any of the following: (circle)

Yes	No	**Heart condition/Heart Attack**	Yes	No	**Stroke**	Yes	No	**Diabetes**
Yes	No	**Asthma**	Yes	No	**High Blood Pressure**	Yes	No	**Low Blood Pressure**
Yes	No	**Anemia**	Yes	No	**Seizures / Epilepsy**	Yes	No	**Severe / Chronic Headaches**
Yes	No	**Arthritis**	Yes	No	**Pacemaker**	Yes	No	**Osteoporosis**
Yes	No	**Kidney Disease**	Yes	No	**Hepatitis / Jaundice**	Yes	No	**Hearing loss**
Yes	No	**Circulatory Problems**	Yes	No	**Recent Weight Gain / Loss**	Yes	No	**Dizziness / Loss of Balance**
Yes	No	**Incontinence**	Yes	No	**Pregnant**	Yes	No	**Cancer**

Other:_____
During the past 5 years have you been admitted to the hospital or had surgery?(circle) **Yes** **No** **If Yes explain:**
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Have you had any previous orthopedic problems, injuries or surgeries?
Date:_____ Diagnosis_____ Date:_____ Diagnosis_____ Date:_____ Diagnosis_____
Date:_____ Diagnosis_____ Date:_____ Diagnosis_____ Date:_____ Diagnosis_____

Patient Signature:_____ **Date**_____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____

Current Medication List

Medication	Dosage	Frequency	How is drug administered?			
			Oral	Transdermal	Suppository	Injection
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
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			☐	☐	☐	☐
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			☐	☐	☐	☐
			☐	☐	☐	☐